repute, but we may safely prophesy a recrudescence before long.

The tuberculin treatment was brought out with a great flourish of trumpets. I believe it is still employed in some quarters, though it has been rather generally discredited.

Some twenty-five years or so ago Calot extolled the healing powers of salt water, combined with certain special plaster of Paris dressings, and if necessary, injection of certain substances into the cold abscess. Calot had quite a vogue. Hospitals were established at the seashore in many places. I had the luck to be in charge of the hospital at Coney Island for a number of years. Our patients had the best of food and care, and generally did well, but the joint tuberculosis ran its accustomed course. To San Franciscans, Calot's treatment will bring back fond memories of Salt Water Keck.

In a state medical meeting I have heard a man of some local prominence detail his cure of joint tuberculosis by painting with iodin, and by adhesive tape.

In the old days bitter fights were waged in orthopedic circles over the respective merits of braces and plaster of Paris. Those who advocated braces differed as to whether the apparatus should simply immobilize, draw the joint surfaces apart and immobilize, or draw them apart and allow motion—motion without friction, as it was called. The main thing was to devise some apparatus with some new gadget which helped in some mysterious way to cure the tuberculous joint.

All these cures had one thing in common: they were based on the clinical opinion of their originator, and no facts supported them except the before and after picture. Peruna has that. However, there is no particular reason why one should not try these various treatments as they come out, if one wishes. Occasionally one stumbles on the truth in that way.

If we are unwilling to pursue the hit or miss course, it might be well for us to demand of the advocate of a new treatment for tuberculous joints the same proof we demand in the case of other organs. If one appeared before a medical society claiming that one could cure endocarditis by injecting something into the blood stream, or appendicitis with sunlight, one would excite derision. It might be true, of course, but some proof besides photographs and case histories would be necessary.

If heliotherapy cures tuberculosis of joints, it should be easy to demonstrate the fact in animals. In all the years of its profitable exploitation this has never been done. Some of the same photographs of miraculously cured patients have been used year after year in different articles, and not one word of proof as to the correctness of the diagnosis, or positive examinations of tissues, or guinea-pig tests, has been submitted. If there is one thing established by careful investigation, it is that a diagnosis of joint tuberculosis without the demonstration of the tubercle bacillus cannot be made. If any clever surgeon doubts this let him take his operative material to the laboratory and look it over.

If he will do that he will learn much more than the fallibility of his diagnosis, for instance this fact: that everything which takes place in and about a tuberculous joint can be interpreted as nature's effort to cure it by destroying function. If he is wise he will imitate nature in his therapeutic efforts, and will view wonder cures with doubting eyes.

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Urology

Chronic Prostatitis—Chronic prostatitis is an exceedingly common disease. It is usually accompanied by vesiculitis. From the resulting prostatovesiculitis much of the pain and worry of man arises.

There are two types: the infective, an aftermath of a gonorrheal infection, and the so-called "aseptic" type, which is more a congestion of the prostate and vesicles than an infection. The latter condition is much more prevalent than is ordinarily supposed, 15 to 25 per cent of cases of prostatitis being non-venereal in origin.[1] Sexual excitement without relief of congestion by a subsequent ejaculation is a frequent cause.[2] Sexual excesses, especially when accompanied by overindulgence in alcohol, masturbation, withdrawal, and other sexual irregularities, will produce this aseptic prostatitis.

Rectal palpation in the chronically infected prostate reveals small hard areas of induration with softer areas between; vesicles are hardened and distended. In the "aseptic" prostatitis the congested prostate is quite large, boggy, and tender, and the vesicles are distended and often tense.

The symptoms of prostatovesiculitis are many and range from a slight "morning drop" and shreds in the urine, to nervous exhaustion. Back pain is the most pronounced and constant symptom, being present in 70 per cent of cases,[3] and the examination of a patient with this complaint is never complete without a thorough check of the prostate and vesicles.[4] Player found that 25 per cent of cases of backache were due to prostatovesiculitis.[3] In the majority of these cases the pain is referred, although a few are due to an arthritis, myositis, or sinusitis, with the prostate and vesicles acting as a focus. Inasmuch as the enervation of the prostate is sympathetic and para-

sympathetic, fibers ending in the prostate arising from the tenth dorsal to the third lumbar segments, the pain from a prostatitis may be referred to any part of the body which is supplied by these segments.[5] A sensation of fullness or an irritation in the perineum, and dull ache in the suprapubic region are symptoms often met with in prostatovesiculitis.[3]

The sexual neurasthenic or even the patient with lesser sexual symptoms is frequently an unwelcome visitor to the physician's office. There is usually a pathological condition causing the symptoms from which these distressed humans suffer, and very frequently this condition is a chronic prostatovesiculitis. Huhner[6] has found cases of sexual neurasthenia, severe depression, nervous exhaustibility and other sexual neuroses due to a chronic prostatitis or a congestion of the prostate; and has cleared them up with treatment for those conditions. The mental anxiety of the patient is far greater than the pathology in the prostate and vesicles would warrant. In some of these cases the patient has been worrying about his condition for years, and it is more difficult to put his mind at ease and convince him that his trouble is not serious than it is to cure the prostatovesiculitis present. These patients must be put on a rigid sexual program. Coitus at regular intervals is beneficial, but ungratified sexual excitement is very harmful, and the patient must be impressed with this fact. In the routine treatment of these cases, the manner in which the prostate is massaged is important. The vesicle on each side is stripped first by reaching as high as possible with the finger in the rectum, then each lobe is massaged with a downward and medial stroke. This expresses the secretion first from the vesicles, then from the prostate into the urethra.

Prostatovesiculitis, both infective and aseptic, is to be thought of in all patients who complain of back pain, of a sensation of fullness in the perineum or suprapubic region, and of sexual difficulties. By routine examination of the prostate the cause of many baffling symptoms may be discovered. Inasmuch as prostatovesiculitis is either caused or aggravated by ungratified sexual desire and sexual irregularities, rigid sexual hygiene is an important item in the routine treatment of these conditions.

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Nutritional Disorders

Migraine—Since time out of mind medical literature has been replete with discussions of migraine. Theories as to its causes are many. For its treatment the list of remedies is as long in number as they each and all are short in value Evidently the disease is much more common than is usually recognized. In its irregular manifestations it undoubtedly plays a much greater part in certain functional diseases than realized; and very often its presence so obscures the clinical picture that a diagnosis of certain organic lesions is difficult and uncertain. We must agree that the causes and cure of this affliction afford a worthy field for research.

A perusal of the literature together with a somewhat close study of clinical cases would seem to warrant several tentative conclusions as to its nature:

1. That it is a specific, inherited, constitutional disease or fault, and ordinarily not acquired.

2. That it is primarily and essentially endocrine in character; as evidenced by its hereditary nature, its relation to other conditions and states in which there is a recognized readjustment in the endocrine system, such as puberty, pregnancy and lactation, the climacteric, menstrual periods, artificial menopause, etc.

3. That either directly or indirectly it involves a specific liver dysfunction which is not explained by such terms as are ordinarily applied to liver disease, organic or functional.

4. That definite, metabolic disturbance is present probably as a result rather than as a cause, though a physiologically invigorated metabolic function tends to prevent or mitigate the migraine explosions.

5. That the sympathetic nervous system is involved, probably, however, through a correlation with the endocrine system.

6. That it often manifests itself in such way that its migraine character is not recognized. The typical headache syndrome being absent, and the outstanding symptoms being nervous irritability, inordinate exhaustion and insomnia, with a state of gastro-intestinal peevishness and rebellion. Careful inquiry into the family and early history of these patients, and in fact into that also of the great majority of our so-called neurasthenics, reveals a definite and often strong migraine background. This form of the disease might well be called irregular migraine.

I believe it can be made evident that each of these several tentative conclusions is consistent with the idea of a single endocrine and metabolic cause; and while the discovery of this specific cause of migraine is only less desirable than the finding of a specific remedy for its relief, yet until the former is revealed, it probably will have to be said of the latter that the time is not yet.

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